EXHIBIT E

faxed 11/16/05

NOTICE AND PROOF OF CLAIM DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY.

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.** USE **GREEN** CLAIM FORM **DB-309** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS.**
2. YOU MUST COMPLETE ALL ITEMS OF **PART A — THE "CLAIMANT'S STATEMENT".** BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B — THE "HEALTH CARE PROVIDER'S STATEMENT".**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

nancy

PART A — CLAIMANT'S STATEMENT (Please Print or Type) **ANSWER ALL QUESTIONS.**

Social Security Number [redacted]

1. My name is Nancy (First) Ellen (Middle) DeNardi (Last)
2. Address 84 (Number) Carroll Dr (Street) Wappingers Falls (City or Town) NY (State) 12590 (ZIP Code) (Apt. No.)
3. Tel. No. [redacted]
4. My age is 48
5. Married (Check one) ☑ Yes ☐ No
6. My disability is (if injury, also state how, when and where it occurred) surgical
7. I became disabled on 10-21-05 (Month / Day / Year)
   a. I worked on that day ☐ Yes ☒ No
   b. I have since worked for wages or profit ☐ Yes ☑ No If "Yes", give dates
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day Yr.	THROUGH Mo. Day Yr.	

9. My job is or was Billing Dept Lead (Occupation) _____ (Name of Union or Local Number, if Member)
10. For the period of disability covered by this claim ☐ Yes ☒ N
    a. Are you receiving wages, salary or separation pay ☐ Yes ☒ N
    b. Are you receiving or claiming:
       (1) Workers' compensation for work-connected disability ☐ Yes ☒ N
       (2) Unemployment Insurance Benefits ☐ Yes ☒ N
       (3) Damages for personal injury ☐ Yes ☒ N
       (4) Benefits under the Federal Social Security Act for long-term disability ☐ Yes ☒ N

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING
    I have ☐ received ☐ claimed from _____ for the period _____ (Date) to _____ (Date)
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ☐ Yes ☒
    If "Yes", fill in the following: I have been paid by _____ from _____ (Date) to _____ (Date)
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; a that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAIN ING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME, AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT:

Claim signed on 11/1/05 (Date) [signature] (Customer Signature)

If signed by other than claimant, print below: name, address and relationship of representative _____

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICI POR INCAPACIDID, COMUNIQUESE CON LA OFICINA MAS CERCANA LA JUNTA DE COMPENSATION OBRERA DE NUEVA YORK, O ESCRIBA WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREA 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

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DB-450 (11/98) HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

NOTICE AND PROOF OF CLAIM DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED** OR BECOMES SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. OTHERWISE USE GREEN CLAIM FORM DB-300.

Doctor's Section

PART B — HEALTH CARE PROVIDERS (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name Nancy E. DeNardi 2. Age 48 3. Sex ☐ Male ☒ Female
4. Diagnosis/Analysis SMALL Bowel obstruction Diagnosis Code
   a. Claimant's Symptoms Abdominal pain, Nausea, Vomiting
   b. Objective Findings CTscan Showed small bowel obstruction
5. Claimant Hospitalized ☒ Yes ☐ No From 10/15/05 To 10/28/05
6. Operation Indicated ☒ Yes ☐ No a. Type exploratory Laparotomy; Colon resection b. Date
7. Enter dates for the following:

	MONTH	DAY	YEAR
a. Date of your first treatment for this disability	10	27	05
b. Date of your most recent treatment for this disability	11	01	05
c. Date claimant was unable to work because of this disability	10	21	05
d. Date claimant will be able to perform usual work	12	05	05

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease ☐ Yes ☒ No
   If "Yes", has form C-4 been filed with the Workers' Compensation Board ☐ Yes ☒ No
   Remarks (attach additional sheet, if necessary) (If disability is pregnancy related, please enter estimated delivery date.)

I affirm that I am a	Licensed in the State of	License Number
☐ Chiropractor ☒ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse — Midwife	NEW YORK	179924

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Health Care Provider's Signature [signature] Date
Health Care Provider's Name (Please Print) EUGENE R. KOLOSKI, MD Tel. No. 845-473-1336
Office Address 205 South Avenue, Poughkeepsie, NY 12601 (Number, Street, City or Town, State, ZIP Code)

Send Pkt to me

Zurich American Insurance Company P. O. Box 9102, Plainview, New York 11803-9002

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Employer's Statement

Employer's Name Imaging Support Services LLC Policy Number 1731369
Employer's Address 1 Columbia St 1st Fl Poughkeepsie ny 12601 Telephone Number 845-454-470
Employee's Name and Address Nancy E DeNardi
Is Employee a ☐ Member ☐ Owner ☐ Partner ☐ Spouse
Date of Employment 9/7/99 ☑ Full-time Worker ☐ Part-time Worker Social Security Number [redacted]
Normal Work Week (Check boxes to show usual days worked) ☐ Sun. ☑ Mon. ☑ Tues. ☑ Wed. ☑ Thurs. ☐ Fri. ☐ Sat.
Date Employee Last Worked 10/7/05 Date Employee Wages Ceased 10/19/05
Has Employee returned to work ☐ Yes ☑ No If "Yes", date
Has employment terminated ☐ Yes ☑ No If "Yes", why

Are wages being continued during disability	☐ Yes	☑ No
If "Yes", does Employer request reimbursement	☐ Yes	☐ No
Was Employee on job when disability occurred	☑ Yes	☐ No
Has claim been filed for Workers' Compensation	☐ Yes	☑ No

Name of Workers' Compensation carrier
Is Employee member of a union that provides for payment of weekly cash benefits ☐ Yes ☑ No
If "Yes", give name, address and telephone number of union

Does Employee contribute to cost of this insurance ☐ Yes ☑ No
If "Yes", is employee contribution the maximum permitted by law ☑ Yes ☐ No Other $ per

Earnings 8 weeks prior to disability; include weekly value of board, lodging and tips.

	WEEK ENDING Mo. Day Year	NO. DAYS WORKED	GROSS AMOUNT
1.	9/10/05	10	1896.
2.	9/24/05	10	1653
3.	10/8/05	10	1556.
4.	10/22/05	7.60	1091
5.			
6.			
7.			
8.			
	TOTAL		$619

Employer tax ID [redacted] Signed [signature] Title Human Resource Date 11/7

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DB-450 (11/98) Reverse